NANSLEDAN CHIROPRACTIC CLINIC

Date……

Shiva Studio, Chi Kresennik An Shoppa, Stret Kosti Veur Woles,
Nansledan, Newquay TR8 4GZ

CONFIDENTIAL PATIENT QUESTIONNAIRE

IT IS **ESSENTIAL** THAT THE FIRST TWO PAGES ARE COMPLETED IN FULL

PERSONAL DETAILS

Surname:	Title: Mr/Mrs/Miss/Dr	Age:
Forename(s):		Date of birth:
Address:	Number of children & ages:	
	Occupation:	Years in job:
	Height:	Weight:
Postcode:	E-mail:	
Tel (home):	Mobile:	Tel (work):
GP's name & address:		
Did your GP refer you? **Yes** / **No** … If not, who referred you?		
Do you have medical insurance? **Yes** / **No** Which company?		

CHIEF COMPLAINT & HISTORY

Main complaint:

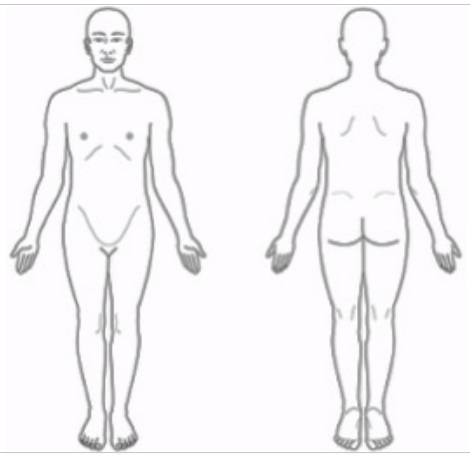
When was the first time you noticed pain in this area?
Describe the **character**/**type** of pain:

On a scale of 1-10(severe), how bad is your worst pain..... and generally…..?

Has the complaint got **worse**, stayed the **same**, or got **better** since it started?

What makes it **worse**?
What makes it **better**?

Have you had any previous diagnosis or treatment? **Yes** / **No**
If **yes** please give details:

Please shade in areas of the adjacent diagram: Pain with: xxxxx Tingling with: ooooo Numbness with: ::::::::::	
Have you lost weight for no apparent reason? **Yes** / **No**	
Have you had night sweats / pain? **Yes** / **No**	
Have you had any change in bowel or bladder function? **Yes** / **No**	
Are you taking any medication / pain relief?	
Any previous tests? (X-rays, MRI, blood tests, urinalysis etc.)	

NANSLEDAN CHIROPRACTIC CLINIC

MEDICAL DETAILS

Can you please give details of your **general health** e.g. any recent changes, any past or present medical conditions? Are you currently receiving any **medical** / **NHS** care?

Have **YOU** or any of your **FAMILY** members suffered with any of the following conditions?

	Self	Family		Self	Family
Allergy & skin disorders			Hiatus hernia		
Alcoholism			Heart disease / Stroke		
Asthma			HIV / Hepatitis		
Blood pressure			IBS		
Cancer			Mental illness		
Diabetes			Osteoporosis		
Epilepsy			Prostate		
Goitre / Thyroid			Rheumatic fever		
Glandular fever			TB		
Headache / Migraine			Other?		

Do you smoke?.....per day Do you drink?.....units per day (1/2 pint=1 unit)
Do you exercise? **Yes** / **No** If yes what type?.....How often?.....per week

Please give details and the dates of any previous…

- Road traffic accidents:
- Sports or other injuries, including fractures:
- Surgery:
- Major illness:

PSYCHOSOCIAL HISTORY

Do you consider yourself under stress?

	Home	Work
Mild		
Moderate		
Severe		

It is my policy to occasionally contact your GP. Do you give your consent: **Yes** / **No**

I understand that co-management of my complaint through a medical doctor (GP) and a chiropractor, in most cases, will be the most effective method of dealing with my complaint.

Finally, please be aware that the clinic will need 24-hour notice to cancel appointments. Unfortunately there is a **50% charge** for appointments cancelled within 24 hours.

Signed…….
Date……..

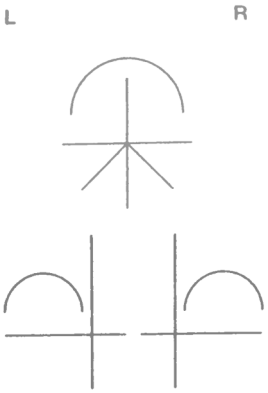
Welcome to the clinic!

PHYSICAL EXAMINATION FORM

Height:	Weight:	B/P:
Resp:	Pulse:	Temp:

General observation:
Pain focus:
Posture:

Range of motion:



X for restriction, O for pain ⊗ if both

Chiropractic:

Spinal Palpation		
	At	
	Ax	
	3C	
	4	
	5	
	6	
	7	
	1T	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1L	
	2	
	3	
	4	
	5	

Gait:

Arches:

Neurological:

Sensation

Muscle

Reflexes

Hoffmans: Valsalva:
Plantar reflex:

Orthopaedic:

Cervical exam:

Lumbar exam:

☒ PI

Cx compression:
Cx distraction:
Doorbell:
Shoulder distraction:
ULNT tests:
TOS tests:

Kemps:
Adams:
Gillet::
Slumps:
SLR:
Braggards:
SIJ compression:
LLI:
Pheasants:

Short leg:

Muscles (TrP's):

Palpation:

CLINICAL IMPRESSION

Diagnosis:

Prognosis: Poor Fair Good Excellent
Treatment plan (frequency & duration):

Consent to treatment: Yes / No
First treatment:

Maintenance to be advised: Yes/No
Patients expectation:

Additional studies:

Home advice:

Cautions: